Complete Summary

GUIDELINE TITLE

Advance directives. In: Evidence-based geriatric nursing protocols for best practice.

BIBLIOGRAPHIC SOURCE(S)

Mitty EL, Ramsey G. Advance directives. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008. p. 539-63. [62 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Ramsey G, Mitty E. Advance directives: protecting patient's rights. In: Mezey M, Fulmer T, Abraham I, Zwicker DA, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 265-91.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

End-of-life condition(s)

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Geriatrics
Nursing

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Hospitals
Nurses
Physician Assistants
Physicians
Utilization Management

GUIDELINE OBJECTIVE(S)

To provide a standard of practice protocol for assisting older adults to make decisions and provide directions about the kind of medical care they do or do not want if they become unable to make decisions or communicate their wishes

TARGET POPULATION

- Hospitalized older adults
- Nursing home residents
- General elderly population

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment

1. Determination if patient has a completed an advance directive
    - Durable power of attorney
    - Living will
2. Advance care planning
3. Decision-making capacity
4. Ability to cope

Management

Assist patients and families with end-of-life care issues

- Culture- and language-appropriate discussions with/education for patient and family/health care proxy about their treatment and care wishes
- Advance directive forms
- Decisions to not complete an advance directive
- Instructional or medical directive
- Oral advance directives
- Conflict mediation
- Referrals to social work, patient advocate, or hospital ethics committee

MAJOR OUTCOMES CONSIDERED

- Number of advance directives completed at or received upon admission to hospital
- Number of referrals to Ethics Committee

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Although the AGREE instrument (which is described in Chapter 1 of the original guideline document) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus the AGREE instrument has been expanded for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions

are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as *Evidence Based Nursing* supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC): In this update of the guideline, the process previously used to develop the geriatric nursing protocols has been enhanced.

Levels of evidence (I – VI) are defined at the end of the "Major Recommendations" field.

Guiding Principals

- All people have the right to decide what will be done with their bodies.
- All individuals are presumed to have decision-making capacity until deemed otherwise.

- All patients who can participate in a conversation, either verbally or through alternate means of communication, should be approached to discuss and record their treatment preferences and wishes.
- Health care professionals can improve the end-of-life care for elderly patients by encouraging the use of advance directives (ADs).

Advance Directives

- Allow individuals to provide directions about the kind of medical care they do or do not want if they become unable to make decisions or communicate their wishes (Rodriquez & Young, 2006 **[Level V]**).
- Provide guidance for health care professionals, families, and substitute decision makers about health care decision making that reflects the person's wishes.
- Provide immunity for health care professionals, families, and appointed proxies from civil and criminal liability when health care professionals follow the AD in good faith.

***Two Types of Advance Directives*: Durable Power of Attorney for Health Care (DPAHC) (also called a Health Care Proxy) and Living Will (LW)**

- A *Durable Power of Attorney* allows individuals to appoint someone, called a health care proxy, agent, or surrogate, to make health care decisions for them should they lose the ability to make decisions or communicate their wishes.
- A *Living Will* provides specific instructions to health care providers about particular kinds of health care treatment an individual would or would not want to prolong life. Living wills are often used to declare a wish to refuse, limit, or withhold life-sustaining treatment.
- Instructional or Medical Directive: Intended to compensate for the weaknesses of LWs, this kind of directive identifies specific interventions that are acceptable to a patient in specific clinical situations.
- Oral Advance Directives (verbal directives) are allowed in some states if there is clear and convincing evidence of the patient's wishes. Clear and convincing evidence can include evidence that the patient made the statement consistently and seriously over time, specifically addressed the actual condition of the patient, and was consistent with the values seen in other areas of the patient's life. Legal rules surrounding oral ADs vary by state.

Assessment Parameters

- All adult patients regardless of age (with the exception of patients with persistent vegetative state, severe dementia, or coma) should be asked if they have a LW or if they have designated a proxy.
- All patients, regardless of age, gender, religion, socioeconomic status, diagnosis, or prognosis, should be approached to discuss ADs and advance care planning.
- Discussions about ADs should be conducted in the patient's preferred language to enable information transfer and questions and answers.
- Patients who have been determined to lack capacity to make other decisions may still have the capacity to designate a proxy or make some health care decisions. Decision-making capacity should be determined for each individual

based on whether the patient has the ability to make the specific decision in question (Mezey et al., 2002 **[Level IV]**).
- If a LW has been completed or proxy has been designated:
    - The document should be readily available on the patient's current chart.
    - The attending physician should know that the directive exists and has a copy.
    - The designated health care proxy should have a copy of the document.
    - The AD should be reviewed periodically by the patient, attending physician/nurse, and the proxy to determine if it reflects the patient's current wishes and preferences.

Care Strategies

- Nurses should assist patients and families trying to deal with end-of-life care issues (Schwartz, et al., 2002 **[Level II]**; Engel, Kiely, & Mitchell, 2006 **[Level II]**).
- Patients may be willing to discuss their health situation and mortality with a nurse or clergyman rather than with a family member and should be supported in doing so.
- Patients should be assisted in talking with their family/proxy about their treatment and care wishes.
- Patients should be assessed for their ability to cope with the information provided.
- Nurses must be mindful of and sensitive to the fact that race, culture, ethnicity, and religion can influence the health care decision-making process. The fact that a patient from non-Western cultures may not subscribe to Western notions of autonomy does not mean that these patients do not want to talk about their treatment wishes or that they would not have conversations with their families about their treatment preferences.
- Patients must be respected for their decision to not complete an AD and reassured that they will not be abandoned or receive substandard care if they do not elect to formulate an AD.
- Nurses should be aware of the institution's mechanism for resolving conflicts between family members and the patient or proxy or between the patient/family and care providers and assist the parties in using this resource.
- Nurses should be aware of which professional in their agency/institution is responsible for checking with the patient that copies of the AD have been given to their primary-care provider(s), to their proxy, *and* that the patient is carrying a wallet-size card with AD and contact information.

Definitions:

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

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Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/Consensus panels

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CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Overall Benefits

Health care professionals, especially nurses, can improve end-of-life decision making for elderly patients by talking about and encouraging the completion of advance directives before the individual loses decisional capacity.

Specific Benefits

- Increased understanding of ethical and legal aspects of advance directives
- Increased number of patients approached about advance directives
- Improved ability to discuss/educate patient and family/health care proxy on advance directives
- Increased number of patients with completed advance directives in chart

POTENTIAL HARMS

Not stated

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

To determine whether implementation of this protocol influenced the type as well as the number of advance directives (ADs) created, changes should be measurable and contribute to the facility's ongoing quality improvement program. Look at:

- As documented in the record:
  - Whether patients are asked about advance care planning and directives
  - Whether patients do or do not have an AD
- Of those patients with an AD, the percentage of ADs included in patient charts
- The use of interpreters to assist staff discussion of ADs with patients for whom English is not their primary language
- The number of ADs completed in association with admission to, or receipt of services from, the agency/institution
- The number of nurse referrals to the Ethics Committee of patient or staff situations regarding ADs

IMPLEMENTATION TOOLS

Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2003 (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

Hartford Institute for Geriatric Nursing - Academic Institution

GUIDELINE DEVELOPER COMMENT

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of The John A. Hartford Foundation Institute for Geriatric Nursing.

SOURCE(S) OF FUNDING

Supported by a grant from The John A. Hartford Foundation.

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Ethel L. Mitty and Gloria Ramsey

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site.

Copies of the book *Geriatric Nursing Protocols for Best Practice*, 3rd edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Advance directives post-test instructions and evaluation: advanced directives. Continuing education activity. Available from the Hartford Institute for Geriatric Nursing Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 2, 2004. The information was verified by the guideline developer on February 26, 2004. This summary was updated by ECRI Institute on June 23, 2008. The updated information was verified by the guideline developer on August 4, 2008.

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